

**NJ DIVISION OF DISABILITY DETERMINATION SERVICES
CLAIMANT - SEIZURE QUESTIONNAIRE**

Name: _____

Address: _____

Social Security Number: _____

1. How long have you been having seizures? _____

2. Date of last seizures? _____

3. How long do they last? _____

4. How many seizures have you had in each of the last 6 months?

Month	Number of seizures
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

5. Do the seizures happen during daytime? ☐ Yes ☐ No **At night while sleeping?** ☐ Yes ☐ No

6. Describe what happens to you as far as you can remember, just before, during and after a seizure.

7. Do you take medicine regularly as instructed? ☐ Yes ☐ No

What is the name of your medicine(s)? _____

8. How often a day do you take each type of medication? _____

9. Name and address of the doctor, hospital or clinic that gave you this prescription? _____

10. How often do you get medicine refilled? _____ .

Give name and telephone number of drug store and prescription number of your medicine.

11. Have you seen a doctor recently for your seizures? [] Yes [] No

If yes, who and when? _____

12. Has your doctor advised you not to drink alcohol? [] Yes [] No

13. Do you drink alcohol? [] Yes [] No

If yes: How often? _____

14. Do you get seizures when you drink or soon after you drink? _____

15. Do you also get seizures when you are not drinking? _____

16. Has a friend or relative, doctor or other person seen you while you were having a seizure? () Yes () No.

If yes, do you authorize this Agency to contact this person to obtain information about your seizure condition. () Yes () No. Please give their name, address, telephone number, and relationship to you.

USE THIS SPACE TO ADD ANY ADDITIONAL INFORMATION ABOUT YOUR SEIZURES.

YOUR SIGNATURE _____

TELEPHONE NUMBER _____ DATE _____